

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> ( ) Yes (x) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-0225-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Motorist Insurance Box 39	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.: 4650163919

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/26/02	11/26/02	97018, 97039-FT	\$61.00	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 08/25/03 states in part, "...We have not received a response from the carrier for our attached billing. Our second request with demand letter was sent to carrier via certified mail and according to the USPS Tracking Confirmation Log, the carrier received on March 10, 2003. The carrier should have responded with 45 days from receipt as required by TWCC.

## PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a response to the TWCC-60 or the request for additional information, signed January 5, 2005.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Codes 97018 and 97039-FT for date of service 11/26/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence (copy of signed green card) of the carrier's receipt of the request for reconsideration. Reimbursement is not recommended.

**PART VI: DETAIL FINDINGS (If needed)**

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
11/26/2002	97018	\$16.00	\$0.00				
11/26/2002	97039-FT	\$45.00	\$0.00				
				Total Left Column:			\$61.00
				Total Amount Due:			\$0.00

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

Marguerite Foster

01-28-05

Authorized Signature

Typed Name

Date of Order

## PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

## PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_